		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024356

Facility Name: Lee Manor

Address: 1301 Lee Street (Number) Des Plaines (City) 60018 (Zip Code)

County: Cook

Telephone Number: (847) 635-4000 **Fax #** (847) 827-5796

IDPA ID Number: 362998136001

Date of Initial License for Current Owners: 6/21/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	282	Skilled (SNF)	282	103,212	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	282	TOTALS	282	103,212	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,860	796	4,142	9,798	8
9	SNF/PED					9
10	ICF	55,241	10,522	427	66,190	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,101	11,318	4,569	75,988	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.62%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 6/21/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 30 and days of care provided 4,033

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	336,211	59,380	5,235	400,826		400,826		400,826			1
2	Food Purchase		299,624		299,624		299,624	(24,311)	275,313			2
3	Housekeeping	252,109	30,601		282,710		282,710		282,710			3
4	Laundry	71,234	48,222		119,456		119,456	(6,245)	113,211			4
5	Heat and Other Utilities			162,063	162,063		162,063	1,440	163,503			5
6	Maintenance	103,400		101,512	204,912		204,912	1,812	206,724			6
7	Other (specify):*											7
8	**TOTAL General Services**	762,954	437,827	268,810	1,469,591		1,469,591	(27,304)	1,442,287			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,229,409	303,750	35,336	3,568,495		3,568,495		3,568,495			10
10a	Therapy			319,373	319,373		319,373		319,373			10a
11	Activities	145,927		28,321	174,248		174,248	11	174,259			11
12	Social Services	37,113		3,524	40,637		40,637		40,637			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,412,449	303,750	395,554	4,111,753		4,111,753	11	4,111,764			16
	C. General Administration											
17	Administrative	144,910		(128,073)	16,837		16,837	128,073	144,910			17
18	Directors Fees											18
19	Professional Services			100,229	100,229		100,229	(21,751)	78,478			19
20	Dues, Fees, Subscriptions & Promotions			45,227	45,227		45,227	1,783	47,010			20
21	Clerical & General Office Expenses	345,335	59,237	36,218	440,790		440,790	11,336	452,126			21
22	Employee Benefits & Payroll Taxes			519,743	519,743		519,743	52,743	572,486			22
23	Inservice Training & Education			623	623		623	179	802			23
24	Travel and Seminar			1,521	1,521		1,521	(109)	1,412			24
25	Other Admin. Staff Transportation			52	52		52	5,602	5,654			25
26	Insurance-Prop.Liab.Malpractice			44,616	44,616		44,616	1,144	45,760			26
27	Other (specify):*											27
28	**TOTAL General Administration**	490,245	59,237	620,156	1,169,638		1,169,638	179,000	1,348,638			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,665,648	800,814	1,284,520	6,750,982		6,750,982	151,707	6,902,689			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lee Manor #0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			64,450	64,450		64,450	145,932	210,382			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,492	91,492		91,492	240,314	331,806			32
33	Real Estate Taxes							361,861	361,861			33
34	Rent-Facility & Grounds			1,221,420	1,221,420		1,221,420	(1,221,420)				34
35	Rent-Equipment & Vehicles			5,140	5,140		5,140	244	5,384			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,382,502	1,382,502		1,382,502	(473,069)	909,433			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,594	27,684	129,278		129,278		129,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,818	154,818		154,818		154,818			42
43	Other (specify):* Nonallowable costs			102,114	102,114		102,114	(102,114)				43
44	**TOTAL Special Cost Centers**		101,594	284,616	386,210		386,210	(102,114)	284,096			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,665,648	902,408	2,951,638	8,519,694		8,519,694	(423,476)	8,096,218			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,245)	4		8
9	Non-Straightline Depreciation	28,269	30		9
10	Interest and Other Investment Income	(20,919)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,306)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(691)	43		18
19	Entertainment				19
20	Contributions	(1,016)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,784)	43		24
25	Fund Raising, Advertising and Promotional	(13,773)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,091)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(12,253)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,809)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(306,667)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (306,667)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (423,476)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lee Manor

ID# 0024356

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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19				19
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77				77
78				78
79				79
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
George Samatas	45.00%	See attached Schedule B		Seneca Building Ltd.		
Eva Dimas	45.00%	Meadowbrook Manor	Bolingbrook	Partnership	Des Plaines	Lessor
		Meadowbrook Manor of Naperville	Naperville			
Chester Plodzien	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Seneca Building Limited Partnership	100.00%	$ 65	$ 65	1
2	V	30	Depreciation		Seneca Building Limited Partnership	100.00%	109,718	109,718	2
3	V	32	Interest		Seneca Building Limited Partnership	100.00%	255,876	255,876	3
4	V	32	Amortization of mortgage costs		Seneca Building Limited Partnership	100.00%	4,048	4,048	4
5	V	33	Real estate taxes		Seneca Building Limited Partnership	100.00%	345,312	345,312	5
6	V	34	Rent	1,221,420	Seneca Building Limited Partnership	100.00%		(1,221,420)	6
7	V	43	State replacement tax		Seneca Building Limited Partnership	100.00%	4,194	4,194	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,221,420			$ 719,213	$ * (502,207)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	0.00%	$ 15,297	$ 15,297	15
16	V	22	FUTA		Royal Management Corp.	0.00%	318	318	16
17	V	22	SUTA		Royal Management Corp.	0.00%	853	853	17
18	V	22	Insurance - W/C		Royal Management Corp.	0.00%	180	180	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	0.00%	7,737	7,737	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	0.00%	4,047	4,047	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	0.00%	2,548	2,548	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	0.00%	1,414	1,414	22
23	V	30	Depreciation - equipment		Royal Management Corp.	0.00%	3,983	3,983	23
24	V	33	Property taxes		Royal Management Corp.	0.00%	991	991	24
25	V	6	Repairs & maintenance		Royal Management Corp.	0.00%	816	816	25
26	V	26	Insurance - general		Royal Management Corp.	0.00%	1,144	1,144	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	0.00%	369	369	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	0.00%	1,203	1,203	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	0.00%	237	237	29
30	V	11	Activities Consultant		Royal Management Corp.	0.00%	11	11	30
31	V	35	Equipment rental		Royal Management Corp.	0.00%	244	244	31
32	V	20	Advertising - help wanted		Royal Management Corp.	0.00%	2,358	2,358	32
33	V	25	Auto expense		Royal Management Corp.	0.00%	5,602	5,602	33
34	V	21	Bank charges		Royal Management Corp.	0.00%	177	177	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	0.00%	3,467	3,467	35
36	V	20	Dues & subscriptions		Royal Management Corp.	0.00%	373	373	36
37	V	21	Office supplies & printing		Royal Management Corp.	0.00%	4,499	4,499	37
38	V	21	Postage		Royal Management Corp.	0.00%	1,679	1,679	38
39	Total			$			$ 59,547	$ * 59,547	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	0.00%	$ 811	$ 811	15
16	V	6	Security service		Royal Management Corp.	0.00%	8	8	16
17	V	21	Telephone		Royal Management Corp.	0.00%	4,803	4,803	17
18	V	21	Communications		Royal Management Corp.	0.00%	345	345	18
19	V	24	Travel & seminar		Royal Management Corp.	0.00%	465	465	19
20	V	32	Interest		Royal Management Corp.	0.00%	1,309	1,309	20
21	V	23	Training & education		Royal Management Corp.	0.00%	179	179	21
22	V	17	Management fees	(128,073)	Royal Management Corp.	0.00%		128,073	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ (128,073)			$ 7,920	$ * 135,993	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Chester Plodzien	Stockholder	Administrative	10.00%	None	40+	100%	Compensation	$ 64,167	L 17, C 1	1
2	James Samatas	Owner/officer	Administrative	0.00%	See Schedule C	4	8%	Salary	17,758	L 17, C 1	2
3	John Samatas	Owner/officer	Admin/Plant Ops	0.00%	See Schedule C	1	2%	Salary	7,892	L 17, C 1	3
4	Cynthia Thiem	Owner/officer	Administrative	0.00%	See Schedule C	1	3%	Salary	9,865	L 17, C 1	4
5	George Samatas	Officer	Administrative	45.00%	See Schedule C	1	2%	Salary	3,157	L 17, C 1	5
6	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	8%	Salary	5,248	L 17, C 1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 108,087		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	51,888	$ 15,297	1
2	22	FUTA	Bed Days	788,945	11	4,830		51,888	318	2
3	22	SUTA	Bed Days	788,945	11	12,967		51,888	853	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		51,888	180	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		51,888	7,737	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		51,888	4,047	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		51,888	2,548	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		51,888	1,414	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		51,888	3,983	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		51,888	991	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		51,888	816	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		51,888	1,144	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		51,888	369	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		51,888	1,203	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		51,888	237	15
16	11	Activity consultant	Bed Days	788,945	11	167		51,888	11	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		51,888	244	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		51,888	2,358	18
19	25	Auto expense	Bed Days	788,945	11	85,184		51,888	5,602	19
20	21	Bank charges	Bed Days	788,945	11	2,695		51,888	177	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		51,888	3,467	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		51,888	373	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		51,888	4,499	23
24	21	Postage	Bed Days	788,945	11	25,535		51,888	1,679	24
25	TOTALS					$ 905,395	$		$ 59,547	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	51,888	$ 811	1
2	6	Security Service	Bed Days	788,945	11	127		51,888	8	2
3	21	Telephone	Bed Days	788,945	11	73,022		51,888	4,803	3
4	21	Communications	Bed Days	788,945	11	5,248		51,888	345	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		51,888	465	5
6	32	Interest	Bed Days	788,945	11	19,899		51,888	1,309	6
7	23	Training & Education	Bed Days	788,945	11	2,716		51,888	179	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 7,920	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mid North Financial Svcs., Inc.		x	Mortgage	$30,415.00	12/31/98	$ 4,000,000	$ 3,806,245	1/1/09	0.0675	$ 260,185	1
2	Hill Rom, Inc.		x	Equipment loan	$466.06	2/3/99	10,100	921	2/3/01	0.1000	379	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank		x	Line of credit	Interest only	7/1/98	1,058,284	1,058,284	6/30/01	0.0872	91,079	6
7												7
8												8
9	TOTAL Facility Related				$30,881.06		$ 5,068,384	$ 4,865,450			$ 351,643	9
	B. Non-Facility Related*											
10							Other miscellaneous interest				34	10
11							Interest income offset				(25,228)	11
12							Amortization of mortgage costs				4,048	12
13							Allocated from management company				1,309	13
14	TOTAL Non-Facility Related						$	$			$ (19,837)	14
15	TOTALS (line 9+line14)						$ 5,068,384	$ 4,865,450			$ 331,806	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 381,000	1
	Allocated from management company	991	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 378,916	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,093)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 390,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 15,558	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 42,604 For 19 92-94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (42,604)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 361,861	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	341,129	8
1996	346,396	9
1997	356,033	10
1998	369,879	11
1999	378,916	12

1999 taxes:	378,916
Estimated increase (3%):	1.03
Estimated 2000 taxes:	390,283
Use:	390,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 106,300 B. General Construction Type: Exterior Brick Frame Fire-proof Brick Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	110,000	1977	$ 273,400	1
2					2
3	TOTALS	110,000		$ 273,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	272		1979	1979	$ 4,087,968	$	40	$ 99,724	$ 99,724	$ 2,211,400	4
5			1979	1979	337,653		40	8,441	8,441	180,944	5
6	10		1985	1985	226,649		40	6,475	6,475	100,363	6
7											7
8											8
	Improvement Type**										
9	Improvements			1979	6,000		N/A				9
10	Improvements			1981	42,962		20	2,148	2,148	40,991	10
11	Audit Adjustment			1979	2,779		40	69	69	1,490	11
12	Audit Adjustment			1981	90,599		40	2,265	2,265	5,907	12
13	Improvements			1983	46,881	3,698	20	2,344	(1,354)	41,525	13
14	Audit Adjustment			1984	25,000		20	1,250	1,250	19,375	14
15	Improvements			1986	36,400	1,893	20	1,820	(73)	26,390	15
16	Improvements			1988	8,536	271	31.5	271		3,275	16
17	Improvements			1989	7,785	247	25	311	64	3,680	17
18	Improvements			1989	9,621	306	15	641	335	7,258	18
19	Improvements			1991	18,843	1,840	15	1,256	(584)	11,845	19
20	Improvements			1992	61,618	1,956	20	3,081	1,125	26,959	20
21	Improvements			1993	4,548	117	20	227	110	1,703	21
22	Improvements			1993	36,719	3,974	40	917	(3,057)	6,419	22
23	Improvements			1994	16,738	1,634	40	418	(1,216)	2,717	23
24	Improvements			1994	8,299	213	40	1,037	824	6,223	24
25	Improvements			1995	8,287	212	40	415	203	2,282	25
26	Improvements			1995	87,711		40	2,156	2,156	11,876	26
27	Brick work			1996	3,040	78	20	152	74	684	27
28	Roof replacement			1996	1,465	38	20	73	35	329	28
29	Facia, overhang renovation			1996	75,200	2,261	39	1,902	(359)	8,572	29
30	Hot water heater			1996	16,084	491	39	417	(74)	1,874	30
31	Insulation			1997	38,770	892	39	994	102	3,479	31
32	Roofing			1997	5,875		39	150	150	525	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,312,030	$ 20,121		$ 138,954	$ 118,833	$ 2,728,085	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Refurbishing of hallways and patient rooms			1997	59,595		20	2,980	2,980	10,659	9
10	Tile			1997	20,696		20	1,035	1,035	3,702	10
11	Electrical improvements			1997	4,112		20	206	206	737	11
12	Plumbing improvements			1997	3,773		20	188	188	673	12
13	Basement remodeling			1998	13,578	347	20	679	332	1,697	13
14	Smoke dampers			1998	2,235	57	20	112	55	280	14
15	Circulating pump			1998	2,630	67	20	132	65	330	15
16	Fire alarm system			1998	4,715	121	20	236	115	590	16
17	Compressor			1998	7,653	196	20	382	186	955	17
18	Boiler valve			1998	3,233	83	20	162	79	405	18
19	Window glazing			1998	2,566	66	20	128	62	320	19
20	Landscaping - stones			1998	977	25	20	48	23	120	20
21	Patio brick			1998	2,590	66	20	130	64	325	21
22	Ceiling tiles			1998	2,233		20	112	112	280	22
23	Window treatments			1998	2,470		20	124	124	310	23
24	Sliding Doors			1999	854	22	20	43	21	64	24
25	Air Conditioning Improvements			1999	685	18	20	34	16	51	25
26	Code Alert Wanderer System			1999	511	13	20	26	13	39	26
27	Elevator Upgrade			1999	50,000	1,282	20	2,500	1,218	3,750	27
28	Roof Improvements			1999	3,567	91	20	178	87	267	28
29	Hallway renovation - ceiling tiles, wiring, painting, doors and tile			2000	40,411	637	39	637		637	29
30	Elevators			2000	20,000	407	39	407		407	30
31	Hallway renovation - labor			2000	9,048	145	39	145		145	31
32	Hallway renovation - materials, painting, and labor			2000	7,303	102	39	102		102	32
33	Painting - labor			2000	2,859	40	39	40		40	33
34	Compressors			2000	20,674	66	39	66		66	34
35	Windows			2000	91,557	294	39	294		294	35
36	TOTAL (lines 4 thru 35)				$ 380,525	$ 4,145		$ 11,126	$ 6,981	$ 27,245	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic doors			2000	1,985	40	39	40		40	9
10	Painting - labor			2000	11,630	112	39	112		112	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 13,615	$ 152		$ 152	$	$ 152	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	6,695		35	207	207	1,052	9
10	Allocated from management company			1996	5,448		35	168	168	701	10
11	Allocated from management company			1989	188		31	6	6	76	11
12	Allocated from management company - HVAC			1998	141		35	4	4	12	12
13	Allocated from management company - Offices			1999	356		35	11	11	15	13
14	Allocated from management company - Offices			2000	169		35	5	5	4	14
15	Allocated from management company			1987	31,296		31	967	967	12,712	15
16	Allocated from management company			1993	17		39	1	1	3	16
17	Allocated from management company			1995	705		39	22	22	99	17
18	Allocated from management company			1996	141		39	4	4	16	18
19	Allocated from management company - Sidewalk			1998	295		39	9	9	18	19
20	Allocated from management company - Roof			1998	11		15	1	1	2	20
21	Allocated from management company - Awnings			1999	182		39	6	6	26	21
22	Allocated from management company - Parking lot			1999	83		15	3	3	3	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 45,727	$		$ 1,414	$ 1,414	$ 14,739	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 305,055	$ 13,809	$ 25,982	$ 12,173	7-15 yrs.	$ 216,005	37
38	Current Year Purchases	173,034	26,223	26,223		3-7 yrs.	26,223	38
39	Fully Depreciated Assets	558,066					558,066	39
40	Allocated from management company	39,242		3,983	3,983		27,771	40
41	TOTALS	$ 1,075,397	$ 40,032	$ 56,188	$ 16,156		$ 828,065	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transport	Wheelchair Lift	1987	$ 2,975	$	$	$		$ 2,975	42
43										43
44										44
45	Allocated from management company			17,001		2,548	2,548		10,449	45
46	TOTALS			$ 19,976	$	$ 2,548	$ 2,548		$ 13,424	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 7,120,670	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 64,450	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 210,382	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 145,932	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,611,710	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,384 Description: Copier - $4,793; Postage meter - $347; Allocated from management company - $244
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	11,064	$ 141,856	$	11,064	$ 141,856	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		1,252	17,037		1,252	17,037	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		14,735	160,480		14,735	160,480	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				101,594		101,594	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Clinitron beds Other (specify): Laboratory	L 39, C 3 L 39, C 3				26,214 1,470			26,214 1,470	13
14	TOTAL			$	27,051	$ 347,057	$ 101,594	27,051	$ 448,651	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 65,363	$ 132,043	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 235,000)	1,160,565	1,160,565	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,771	12,771	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	422,751	24,302	8
9	Other(specify): See attached Schedule C		281,576	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,661,450	$ 1,611,257	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,400	13
14	Buildings, at Historical Cost		4,894,581	14
15	Leasehold Improvements, at Historical Cost	931,250	857,316	15
16	Equipment, at Historical Cost	1,044,443	1,095,373	16
17	Accumulated Depreciation (book methods)	(1,249,354)	(3,611,710)	17
18	Deferred Charges		13,290	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		36,430	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 726,339	$ 3,558,680	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,387,789	$ 5,169,937	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 506,382	$ 506,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,426	87,426	28
29	Short-Term Notes Payable	1,059,205	1,170,665	29
30	Accrued Salaries Payable	178,604	178,604	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,000	8,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)		390,000	32
33	Accrued Interest Payable		21,410	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	157	157	35
	Other Current Liabilities(specify):			
36	See attached Schedule C	68,929	71,929	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,908,703	$ 2,434,573	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,694,785	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,694,785	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,908,703	$ 6,129,358	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 479,086	$ (959,421)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,387,789	$ 5,169,937	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 242,477	1
2	Restatements (describe):		2
3	**Rounding difference**	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 242,475	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	400,111	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(163,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 236,611	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 479,086	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,430,970	1
2	Discounts and Allowances for all Levels	(330,695)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,100,275	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	474,361	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 474,361	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,957	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,784	19
20	Radiology and X-Ray		20
21	Other Medical Services	199,150	21
22	Laundry	6,245	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 322,136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,919	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,919	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Equipment rental income & miscellaneous income	2,114	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,114	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,919,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,469,591	31
32	Health Care	4,111,753	32
33	General Administration	1,169,638	33
	B. Capital Expense		
34	Ownership	1,382,502	34
	C. Ancillary Expense		
35	Special Cost Centers	231,392	35
36	Provider Participation Fee	154,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,519,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	400,111	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 400,111	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,524	1,524	$ 61,085	$ 40.08	1
2	Assistant Director of Nursing	3,768	4,063	85,022	20.93	2
3	Registered Nurses	68,382	73,693	1,559,026	21.16	3
4	Licensed Practical Nurses	162	190	3,205	16.87	4
5	Nurse Aides & Orderlies	126,124	133,626	1,376,068	10.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,863	13,966	145,003	10.38	8
9	Activity Director	1,334	1,420	19,210	13.53	9
10	Activity Assistants	15,828	16,439	126,717	7.71	10
11	Social Service Workers	1,713	1,825	37,113	20.34	11
12	Dietician	130	138	2,822	20.45	12
13	Food Service Supervisor	2,753	2,889	52,206	18.07	13
14	Head Cook	2,303	2,419	25,279	10.45	14
15	Cook Helpers/Assistants	13,057	13,868	108,686	7.84	15
16	Dishwashers	23,907	24,788	147,218	5.94	16
17	Maintenance Workers	7,393	7,814	103,400	13.23	17
18	Housekeepers	35,361	37,144	252,109	6.79	18
19	Laundry	10,265	11,027	71,234	6.46	19
20	Administrator	749	749	36,823	49.16	20
21	Assistant Administrator					21
22	Other Administrative	2,507	2,518	108,087	42.93	22
23	Office Manager					23
24	Clerical	20,854	22,092	345,335	15.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	350,977	372,192	$ 4,665,648 *	$ 12.54	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,235	L 1, C 3	35
36	Medical Director	Monthly	9,000	L 9, C 3	36
37	Medical Records Consultant	5	250	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	120	3,573	L 11, C 3	44
45	Social Service Consultant	65	3,149	L 12, C 3	45
46	Other(specify)				46
47	Religious Consultant	Monthly	375	L 12, C 3	47
48					48
49	TOTAL (lines 35 - 48)	190	$ 22,782		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	44	$ 1,096	L 10, C 3	50
51	Licensed Practical Nurses	132	2,904	L 10, C 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	176	$ 4,000		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chester Plodzien	Administrative	10.00%	$ 64,167
Lori McCullom	Administrator	0.00%	36,823
John Samatas	Admin/Plant Ops	0.00%	7,892
James Samatas	Administrative	0.00%	17,758
Cynthia Thiem	Administrative	0.00%	9,865
George Samatas	Administrative	45.00%	3,157
Jason Samatas	Administrative	0.00%	5,248
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 144,910

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ (128,073)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ (128,073)

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 11,071
American Express Tax & Bus. Svcs.	Accounting	26,532
Carrie Deato	Consulting	880
Freidman, Anselmo & Lindburg	Collections	650
McCracken, Walsh, et al	Legal	26,144
Millenium	Payroll Services	4,250
New England Fin. Benefits Group	401(k) Administration	500
Personnel Planners	U/C Consulting	665
James Samatas	Legal	50
Robert Stachura	Accounting	65
Systematic Management Systems	Billing Consultant	29,084
Web Presence	Web Site Development	338
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 100,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,315
Unemployment Compensation Insurance	25,211
FICA Taxes	336,544
Employee Health Insurance	147,235
Employee Meals	24,311
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	1,542
Employee Uniforms	1,181
Other Employee Benefits	8,147
TOTAL (agree to Schedule V, line 22, col.8)	$ 572,486

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	24,793
Health Care Worker Background Check	
(Indicate # of checks performed 18)	216
Miscellaneous dues & subscriptions	1,600
Miscellaneous licenses & permits	1,278
Illinois Council on Long-Term Care	11,567
Extended Care Information Network	4,425
Allocated from management company	2,731
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	947
Allocated from management company	465
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,412

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	Various 1997	$ 15,455	36 mo.	$ 2,576	$ 5,152	$ 5,152	$ 2,575	$	$	$	$	$
2	Painting and Decorating	Various 1998	12,218	36 mo.		2,037	4,072	4,072	2,037				
3	Painting and Decorating	Various 1999	6,270	36 mo.			1,045	2,090	2,090	1,045			
4	Painting and Decorating	Various 2000	4,058	36 mo.				676	1,353	1,353	676		
5	HVAC Repairs & Maint.	May 2000	1,609	36 mo.				268	536	536	269		
6	HVAC Repairs & Maint.	August 2000	4,074	36 mo.				679	1,358	1,358	679		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 43,684		$ 2,576	$ 7,189	$ 10,269	$ 10,360	$ 7,374	$ 4,292	$ 1,624	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor **#** 0024356 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $11,567; ECIN - $4,425**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,516** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **154,818**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,311** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.